Confidential Communication Request Form

Thank you for choosing Alameda Alliance for Health (Alliance). We are your partner in health. As an Alliance member, you have the right to choose how your protected health information (PHI) is shared. You may ask that we only contact you by mail, email (emails will be sent securely), or phone.

To request confidential (private) medical communications, you must submit this form to:

Alameda Alliance for Health
ATTN: Member Services Department
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4504**
Email: **memberservices@alamedaalliance.org**

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____

Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

SECTION 2: HOW TO RECEIVE CONFIDENTIAL COMMUNICATION

I request that communications that have confidential (private) information be sent to me by (please select all that apply):

☐ Mail to this preferred address:

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Email to: _____

☐ Phone by calling: _____ ☐ Home ☐ Cell

SECTION 3: SIGNATURE

By signing below, I confirm that the above information is true and correct. I want this change in communication until I cancel it or submit a new Confidential Communication Request Form.

If you are signing for the member, describe your relationship below. If you are the member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

Signature: _____ Date: _____

Relationship if signing for the member: _____